

## Centers for Medicare & Medicaid Services, HHS

## § 413.83

results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

[69 FR 49254, Aug. 11, 2004]

### **§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.**

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date

the resident began training in that program, whichever comes first.

[69 FR 49254, Aug. 11, 2004]

### **§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.**

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note))) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(c) Per resident amounts are determined for the base period and updated as described in § 413.77. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in § 413.76.

[69 FR 49254, Aug. 11, 2004]

### **§ 413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.**

(a) *Misclassified operating costs—(1) General rule.* If a hospital has its base-period GME costs reduced under § 413.77(a) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the

hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(b) *Misclassification of GME costs—(1) General rule.* If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of

the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

[69 FR 49254, Aug. 11, 2004]

**§ 413.85 Cost of approved nursing and allied health education activities.**

(a) *Statutory basis.* This section implements section 1861(v)(1)(A) of the Act and section 4004(b) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508) by establishing the methodology for Medicare payment of the costs of approved nursing and allied health education activities.

(b) *Scope.* (1) This section sets forth the rules for determining Medicare payments to hospitals for the costs of nursing and allied health education activities.

(2) This section does not address Medicare payments for the direct and indirect costs of graduate medical education (that is, approved residency programs in medicine, osteopathy, dentistry, and podiatry). Medicare payment for these costs is determined as provided in § 412.105 of this subchapter and §§ 413.75 through 413.83.

(3) The rules under this section do not apply to activities that are specified in paragraph (h) of this section and identified as normal operating costs.

(c) *Definitions.* For purposes of this section, the following definitions apply:

*Approved educational activities* means formally organized or planned programs of study of the type that:

(1) Are operated by providers as specified in paragraph (f) of this section;

(2) Enhance the quality of health care at the provider; and

(3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation.